Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

Respondent Name
CITY OF AUSTIN

Carrier's Austin Representative Box
Box Number 43

MFDR Tracking Number
M4-13-1623-01

MFDR Date Received
JANUARY 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary stated in letter addressed to Manuel Acevedo, TDI/DWC, dated December 6, 2012: "I was instructed by your main office in Austin to contact you regarding my workers comp claim on 5-8-12 with the City of Austin regarding my hearing loss. I received this letter from JI Specialty Services which represents the City of Austin stating that my claim has been accepted and is compensable, and I would be able to get hearing aids for my hearing loss. I called the representative with JI Specialty and told them that I had already purchased hearing aids on September 21, 2010 at my own expense since by hearing loss was significant and I needed them. I asked her would it be possible to be reimbursed for my out of pocket expenses and she stated that no they could not go back and reimburse me. I also advised the representative that I had spoken to a workers comp representative with the City of Austin in Sept. 2010, regarding filing a workers comp case on my hearing loss and she stated that it would be doubtful that I would be successful since this was an accumulative loss and not one specific incident. So that was the reason I did not try to file a works comp case on my hearing loss then, but after several other co-workers had filed works comp cases on hearing loss this year and was successful, I then decided to in May 2012. The JI Specialty representative still said no that they could not go back and reimburse me but only pay for hearing aids in the future."

Amount in Dispute: $6,350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The request for reimbursement of hearing aid paid for, out of pocket, by the claimant have been denied as the claimant did not file his hearing loss claim until June 21, 2012. The hearing aides were purchased two (2) years and three (3) months prior to the report of injury."

Response Submitted by: JI Specialty Services, PO Box 26655, Austin, TX 78755

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2010	Out of Pocket Expenses for hearing aids	$6,350.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits was not submitted by either party.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in a timely manner?

Findings

1. In accordance with 28 Texas Administrative Code §133.307, a requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. According to §133.307(c), a request for MFDR shall be filed no later than one year after the date(s) of service in dispute. Review of documentation provided finds that date of service in dispute is September 9, 2010. Based upon the date that this medical fee dispute was received in MFDR, January 29, 2013, the division concludes that:
   - date of service September 9, 2010 was not submitted timely to MFDR; therefore the requestor has waived its right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 16, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.